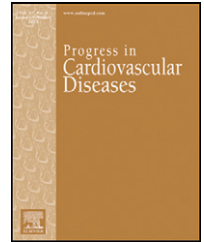


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Palliative Care in Heart Failure

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ABSTRACT

Heart failure (HF) is a leading cause of morbidity and mortality worldwide, with limited curative options. Palliative care is a holistic, symptom based approach to patients that has been proven to improve the quality of life for both patients and their caregivers. In this review we will summarize the epidemiology of end stage HF and the data supporting the use of palliative care in this patient population. We will also review basic principles of palliative care as they apply to caring for end stage patients.

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Heart failure (HF) is a rapidly expanding epidemic worldwide. Nearly 5% of the 23 million people with HF have end-stage disease refractory to medical therapy [American College of Cardiology (ACC)/American Heart Association (AHA) stage D HF]. Given that only a small fraction of these patients will receive heart transplant (HT) or mechanical ventricular assist devices (VADs), many of these patients will succumb to their disease within one year. End-stage HF is associated with tremendous impact on the quality of life (QoL) for both patients and caregivers. Lowered self-esteem, social isolation, co-morbidity, frustration, and little planned community support compound the issue.

Despite the tremendous technological and medical advances in the field of cardiovascular diseases (CVD) there are very limited curative options for patients with advanced HF and most of the efforts have focused on palliation and symptom relief. Palliative care has demonstrated to improve the QoL in patients with end-stage HF. In recognition of the important role of palliative care in patients with advanced HF, referral to palliative medicine was made a 1A recommendation in recent ACC and AHA guidelines HF guidelines.¹

In this review, we describe the burden of HF on patients and their families and the role of palliative care in this complex patient population. We present evidence supporting the initiation of palliative care in patients with HF. We also

explore the role of palliation in conjunction with advanced therapeutics such as VADs. We conclude with our recommendations on how to improve adoption of palliative care among physicians.

The burden of heart failure

More than 23 million individuals have HF worldwide,² which carries substantial morbidity and mortality and is particularly prevalent in the older population, affecting about 50% of patients over the age of 65.² Recent studies have shown increasing incidence and survival of patients with HF, resulting in a growing population of patients with symptomatic HF.²

Heart failure also represents a significant burden to the health care system. The estimated yearly cost of HF in the United States is \$39 billion annually.³ Much of this cost relates to the more than 1 million people who are hospitalized with a primary diagnosis of HF. The mean hospital length of stay is almost 6 days, and more than a third of patients are admitted for more than 5 days.³ The cost of nearly half of the hospitalizations for HF exceeds Medicare reimbursement, which places a significant financial burden on hospitals and healthcare systems.⁴ When compared to all hospitalized patients, those with HF incur greater health care costs through

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Abbreviations and Acronyms

ACC = American College of Cardiology

AHA = American Heart Association

CVD = cardiovascular diseases

HF = heart failure

ICDs = implantable cardiac defibrillators

QoL = quality of life

SCD = sudden cardiac death

HT = heart transplant

VAD = ventricular assist devices

increased physician visits, hospital admissions, and twice as many days in intensive care units.⁴

End-stage HF as defined by ACC/AHA guidelines⁵ includes a subset of patients with HF who continue to have significant symptoms despite maximum goal directed medical therapy (GDMT). These patients are often characterized by severe symptoms of HF, such as dyspnea and/or fatigue at rest or with minimal exertion.

End-stage HF has a large impact on the QoL of patients and caregivers and is associated with increasing health care costs.⁶ One of the most important goals of patient care is improving the QoL and providing symptom relief. Palliative medicine plays a crucial role in this regard.

Palliative medicine focuses on end-of-life care, which includes managing patients with life limiting illnesses and assisting families throughout the course of the disease. The psychosocial distress related to life limiting illness begins with the early stages of diagnosis and continues throughout treatment course. The goal of palliative care is to prevent and relieve suffering and to facilitate the best possible QoL for patients and their families regardless of disease stage.⁷ The goal of palliative care is to ameliorate suffering by identifying, assessing, and treating physical, psychosocial, and spiritual problems early on.⁸ Meanwhile, palliative care also helps patients maintain a sense of control, relieve burden to others, and strengthen relationships with loved ones.⁹ Palliative care should be differentiated from hospice care, as palliative care can be provided along with life-sustaining treatment while hospice care emphasizes on symptom management without life-prolonging treatments.

Hospice is more specifically palliative care that is offered to patients at the end of life when curative or life prolonging therapy is no longer beneficial. It is typically provided to patients when mortality is likely to be within less than six months. Determining when to transition from non-hospice palliative care to hospice can be difficult and should be a group decision made among patients, family members, and health care providers. A variety of prognostic tools have been developed to assist physicians in the care of the advanced HF patient, including the EFFECT model, the Heart Failure Survival Score and Seattle Heart Failure Model.^{10–13} These systems can be of great help to physicians and family members who are trying to determine when the transition to hospice is appropriate.

Palliative care promotes patients' well-being and dignity by facilitating communication between patients and healthcare providers, providing emotional and spiritual support to the patients and families, and introducing

available resources. There is strong evidence in the literature supporting the role of palliative care in ameliorating patients' symptoms, including dyspnea, chest pain, anxiety and helping patients and caregivers cope with the life style changes.¹⁰ In a study evaluating the dying experience at home and at institutional settings among 1578 patients, it was noted that families of patients receiving palliative care were more satisfied with overall quality of care, with 70.7% rating care as "excellent" compared to less than 50% of those dying without palliative services.¹⁴ Patients who received in-home palliative care were also more likely to die at home, which is consistent with the expressed wishes of most patients.¹⁵ While the goal of palliative care is to improve QoL and neither prolong life nor hasten death, a study by Connor et al. has surprisingly shown that palliative care improves survival for patients with HF by about 81 days within a three year period.¹⁶ This increased longevity may be due to avoidance of aggressive measures that carry significant risk, improved monitoring of patients for pain and other symptoms, receipt of interdisciplinary care, and presence of psychosocial support for care providers. Palliative care consultations have also shown to reduce hospital readmissions. In a recent study evaluating the impact of palliative care on 30-day hospital readmissions, 1430 hospitals were studied over a one-year period. It was determined that palliative care consultations, which facilitated goals of care discussions, were associated with reduced rates of 30-day readmissions.¹⁷ It is thus critical to consider implementing palliative care in patients initially diagnosed with end-stage heart failure in order to decrease over-utilization of health care resources and avoid unnecessary aggressive care.

In 2005, the ACC/AHA guidelines for HF were updated to include end of life care as a class 1A recommendation.¹⁶ Class I indication includes ongoing discussions with patients and families about prognosis for functional capacity and survival, advance directives, palliative care and hospice care, option of inactivation of implantable cardiac defibrillators (ICDs), as well as provision of care geared toward symptom management including use of opiates, and continued use of inotropes and intravenous diuretics. The guidelines state that aggressive procedures performed at the end of life that do not contribute to recovery or improve QoL, including intubation and implantation of an ICD, are not appropriate. Additionally, the guidelines direct providers to discuss end of life options with the patient and their family when symptoms persist despite GDMT. The 2005 ACC/AHA guidelines state, "As we become more familiar with the steps in progression to end-stage HF in this era, the current abrupt transition from aggressive intervention to comfort and bereavement care will be softened by a gradual and progressive emphasis on palliation until it dominates the final days of care."

Palliative care not only aims to relieve suffering and improve QoL in patients with HF, but more importantly helps patients with life-limiting disease and their caregivers prepare for different outcomes by encompassing a holistic approach that addresses physical, emotional, spiritual, and logistical needs. Since HF is a life-limiting disease, patients with HF meet criteria needed to take advantage of palliative

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